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Occupational Therapy Practice Strategies to Reduce Recidivism Rates in the Chronically Mentally Ill

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Master's Scholarly Project

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Chapter 1: Introduction

Rehospitalization of psychiatric patients in urban communities is one of the most prominent problems today in psychiatry. The chronically mentally ill (CMI) population often struggle to get their needs met in society due to the lack of adequate community based services and access to general health, social and disability services. Even with an adequately funded community service system, these "revolving door" patients may accumulate a lifetime rate of more than 100 admissions which characterizes the client's inability to remain in the community for extended periods of time (Gibson, 1995; Yamada, Korman & Hughes, 2000). Problematic areas identified within this population include noncompliance with medication and/or planned aftercare, the stigma in society towards the mentally ill, poor social interaction skills, poor physical health, community living skills, difficulty adjusting to community residences upon discharge, difficulty achieving and maintaining employment, and a lack of consumer choice.

Occupational therapists have the knowledge and ability to address these problematic areas with the CMI population in order to teach the skills needed to survive within the community. OT's are also capable of connecting this clientele with community support services that will accommodate their needs and assist in maintaining the skills required to ensure a successful community reintegration.

Recent studies have reviewed the effectiveness of different treatment approaches in each of the areas stated above. In order to ensure a successful reintegration into the community a holistic approach should be used to identify the needed skills and environmental supports required to fulfill the tasks and roles of daily living.

Models are implemented in occupational therapy practice to identify what phenomena the treatment should focus on and provide an organized way of thinking about a certain phenomenon while evaluating the person, environment, health, and occupation. Models specific to the psychiatric population that have proven useful in guiding occupational therapy treatment are the Model of Human Occupation and Cognitive Rehabiliation. Other models, not specific to the Occupational Therapy domain, used within psychiatric treatment are Social Rehabilitation and Psychiatric Rehabilitation.

The purpose of this project is the development of practice strategies focusing on the areas of concern for the chronically mentally ill and recommended occupational therapy strategies to assist in successful community reintegration. It is anticipated that these program guidelines can be used by occupational therapists treating the chronically mentally ill within urban communities.

Chapter 2: Review of Literature

The review of the literature provides an overview of the current problems and difficulties associated with the chronically mentally ill population including their inability to remain within the community. Current system problems and individual needs are addressed within the literature. Treatment methods, assessment guidelines and treatment models are all included in creating an extensive overview of the treatment methods and needs of the chronically mentally ill (CMI) population.

The literature guides a discussion of the results and consequences the deinstitutionalization movement had on the system, the mentally ill and their families or support networks. This reintegration of the CMI population into the community has resulted in numerous unforeseen difficulties for the individual with mental illness, their care givers and treatment facilities that remain unresolved to this date. While community support systems are more available now than ever, the "revolving door" syndrome is still an issue for the CMI population.

This review of the literature will discuss individual needs and treatment guidelines. Included in the discussion are procedures for using assessments, treatment methods for societal stigma, social interaction skills, community living skills, health/self care, community residences, employment/work, and the lack of consumer choice. Occupational therapy treatment models provide information on how treatment interventions are influenced based upon the underlying principles of the models. The models reviewed in the work include the Model of Human Occupation, Cognitive Rehabilitation, Social Rehabilitation and Psychiatric Rehabilitation.

The review of the literature is intended to provide knowledge about the CMI population and their struggles within the community. Based upon their needs and difficulties, treatment interventions can be created focusing on their areas of concern while based upon treatment models.

The mental health reform that began thirty years ago with the deinstitutionalization of clients requiring mental health care led to the dramatic decrease in state hospital admissions. State hospitals now care for persons with mental illness with multiple short term inpatient hospitalizations rather than prolonged inpatient stays that once hallmarked psychiatric institutionalization. However, this has resulted in an increase of rehospitalizations from the population defined as having a chronic mental illness (CMI).

Current System Problems

The reintegration of the CMI population into the community has resulted in numerous unforeseen difficulties for the individual with the mental illness, their care givers and treatment facilities that remain unresolved to this date. Problems associated with deinstitutionalization include an increased stress on families since they are the primary care givers and have limited community supports, a lack of adequate community based services and access to general health, social and disability services (Lloyd, Kamowski & Samra, 1998). These problems may have been the result of underlying assumptions of deinstitutionalization; for example, that people with CMI treated in the community had places to live, had caring families/guardians who would take responsibility for their care and that home structures would not inhibit their rehabilitation. Unfortunately, many individuals with CMI discharged into the community have no families and find themselves homeless. It is obvious that policymakers, clinicians and

rehabilitation professionals in their process of implementing deinstitutionalization may not have grasped the complexities and difficulties that people with CMI experience when living in the community (Accordino, Porter, & Morse, 2001). To this day state hospital facilities continue to struggle with managing persons with mental illness who tend to be treatment resistant or who need continuing care services beyond what the private sector provides (Gibson, 1999).

The direction and quality of health care delivered to clients with a mental illness since deinstitutionalization has been a major concern of the mental health system. This is due to the fact that the health care of persons with CMI has received little attention, even though they have a higher rate of both acute and chronic mental illness than the general population, along with a higher prevalence of problematic health problems (Getty & Perese, 1998). There is a lack of services provided to this population, including insufficient resources for the provision of residential care, day treatment, outpatient psychotherapy, crisis intervention and case management. Of greater concern is the lack of continuity of care of clients who have been hospitalized, medicated and then discharged into the community (Gibson, 1999).

Individual Needs

Rehospitalizations remain one of the most significant problems in psychiatry today despite the development of community resources and shifting the focus from inpatient state mental health facility to the community. Even with an adequately funded community service system these "revolving door" patients may accumulate a lifetime rate of more than 100 admissions which characterizes the client's inability to remain in the community for extended periods of time (Gibson, 1995; Yamada, Korman & Hughes,

2000). Studies have found associations between readmission and medication noncompliance, smaller, more dense social networks, low levels of functioning, inadequate psychosocial support systems, current situational factors, early age of onset of illness and first admission date. These recurrent admissions often occur for nonpsychiatric reasons, such as no income, no place to live, or no food (Perese, 1997; Kent & Yellowlees, 1994). The revolving "in and out" of inpatient treatment, discharge, decompensation within the community and then readmission consumes healthcare resources that would better be spent in providing holistic services that facilitate reintegration and maintenance within the community (Gibson, 1995).

The two major reasons for rehospitalizations have been identified as noncompliance with medications or planned aftercare (Community project, 1994). The individual with the mental illness, once discharged from the inpatient setting, is often unmotivated or unable to participate in such a system that is designed to eliminate problems resulting in un-utilized community resources which promote the revolving door pattern. Symptoms of mental disorders, such as hallucinations, delusions, cognitive impairment, paranoia, apathy, withdrawal and depression, may also interfere with an individual's ability to seek health care and follow through with recommendations (Talley, 1988).

Linkage to aftercare services must be incorporated into the plan of care before an individual with a mental illness (MI) can be discharged from the inpatient setting and continuity of care can be maintained in the community (Gibson, 1999). Mental health providers have described a so called "critical window" of time during which the clients are most at risk for noncompliance. The "critical window" occurs after the client is

discharged from inpatient hospitalization and before the first appointment for outpatient treatment. During the "critical window," many clients experience a personal or mental health crisis and need connections with the health care system. Telephone follow-up calls within 48 hours of discharge contribute to continuity of care, provides support and offers an opportunity to assess new client medications (Community project, 1994). Case managers are useful means of monitoring clients' needs within the community. They allow for continuous tracking of a client and evaluation of progress. Klinkenberg and Calsyn (1996) found that the scheduling of specific aftercare appointments was more important in determining follow up compliance than was the development of a relationship between the client and the aftercare provider.

Communication and collaboration must exist between state hospital facilities and aftercare programs if continuity of care is to be enhanced along with client motivation to participate in follow up care. Community support program services should be geared to assist former psychiatric patients with survival, treatment compliance, rehabilitation and independent living. Support services may include continued staff/client interaction, case management, medication monitoring and scheduled follow up appointments with the psychiatrist (Gibson, 1995).

Systematic interventions, such as standard discharge planning and coordinated post discharge follow up can help prevent rehospitalizations. Collaborative discharge planning, which is the process involving the client's community support system before hospital release, should take place. This involves pre-establishing linkages to existing community-based services, such as partial hospitalization programs or group homes. A discharge planning checklist can provide a structured comprehensive format for

coordinating client aftercare. Key elements in the structured format usually include demographics, social and personal resources, anticipated needs of the follow up care, information on medications and follow up appointments (Community project, 1994). With this format, staff and client can be ensured that follow up care is established along with information the client can refer to in order to secure a successful discharge.

Unfortunately, as persons with CMI are being reintegrated into society, negative community attitudes have made community settings uncomfortable for these individuals (Accordino et al., 2001). People with severe mental health problems are a disadvantaged group in society and the stigma associated with being mentally ill has caused fear, misunderstanding and discrimination. This is a factor in vocational deprivation in so far as it limits access to resources and mainstream social contact (Fieldhouse, 2000) Persons with disabilities often feel that their major problems stem from the negative perception that they receive as opposed to their physical or mental impairments. Research has shown that misconceptions and stigma associated with mental illness are for the most part to blame for the lack of access to mainstream community services. The best type of interventions to address the negative perception includes; protesting against current negative attitudes portrayed in society, especially the media; education on negative attitudes and ways to combat them; and promoting contact between people with CMI and the general public (Accordino et al, 2001).

In order to adapt to the stressors associated with living in a community, where individuals with CMI may not be wanted or resources are scattered, they must be able to meet their basic needs and the special needs related to their illness to achieve a quality of life that includes safety, stability and purpose (Vorspan, 1988; Lehman, 1988; Stein,

1992; Torrey, 1995; Ungar & Anthony, 1984). These special needs include protection and advocacy to help maintain personal safety; health care that encompasses continuing psychiatric care as well as physical and dental care; information and help in relationships with families, landlords, employer's and members of the community and coordination of services of different agencies through case management. Perese (1997) identified the basic needs of persons in the process of adapting to stressors include basic survival provisions such as food, housing, clothing, transportation and information. These basic needs also encompass a clear concept of identity; one person in a close relationship; a group that claims the person as a member; a role in life; money or financial resources along with a system of meaning or set of beliefs.

Further, Perese (1997) identified the needs of the chronically mentally ill in Erie, Pennsylvania. Seventy-three members of the Erie Alliance for the Mentally Ill were administered a questionnaire that elicited their perceptions of need satisfaction and Lehman's Life Satisfaction Scale to measure quality of life. Needs for a friend, a role in life and membership in a group were frequently identified as unmet. It was the stigma, represented by the need for information and help for people in the community as they interacted with persons with a mental illness, that showed the strongest negative correlation with quality of life. Appropriate interventions include meeting the needs of individuals with the goal of promoting health and a sense of well being.

People with mental illness need skills and environmental supports to fulfill the required tasks and roles of daily living. It has been found that by providing skill development programs in conjunction with the development of social supports and networks, their rehabilitation outcomes can be improved (Anthony & Lieberman, 1986).

This method enables the client to learn the skills needed for daily activities and roles along with providing environmental supports, which otherwise may not have been utilized. Helping clients with psychiatric disabilities to escape from the role of dependency by "returning to normal function" becomes more important in treatment perspective than symptom control and reduced hospitalization (Drake, 1998; Meuser et al., 1997).

Treatment

In order to successfully treat the CMI population, all aspects of the individual must be considered and treated, ranging from daily living skills to their environment. Gibson (1995) suggests a holistic approach in the delivery of care to persons with a mental illness (MI), beginning with rehabilitation that targets psychosocial functioning and extends into a community support program that maintains rehabilitation. Inpatient services for persons with MI should be aimed at providing the highest quality of psychiatric and psychosocial treatment and rehabilitation. The goal of inpatient rehabilitation services should be directed toward returning individuals with MI to the community by producing measurable gains in functioning that promote increased personal independence, self direction and care to prepare the patient to live in the least restrictive environment (Boyd, Morris, Turner, & Little, 1991). The combined approaches of a psychosocial rehabilitation-education program are believed to provide for the highest attainment of patient autonomy along with the combined approach of rehabilitation, aftercare, community support program, family support and managed care contribute to the reintegration of persons with MI into their community.

Treatment should focus around decreasing the family's burden of care by providing opportunities for clients to learn skills in real life situations, implementing an individualized, ongoing treatment program defined by client's needs, involving all needed support systems for holistic treatment of clients, promoting mental health through the use of a vast array of resources and treatment modalities and finally, emphasizing and promoting client independence (De Cangas, 1997).

In a study by McFarlane, Dushay, Stastny, Deakins & Link (1996), it was discovered that including families in the treatment plan does not exacerbate the client's symptoms and may help to reduce family's burden of care. Data has shown those high risk clients who participate in treatment with their families in multifamily support groups had significantly better outcomes than in single family treatment. Family interventions include skills training, psychoeducation, and training in the reduction of expressed emotion and crisis intervention. Family involvement increasingly has been recognized as a vital component in the treatment and care of the mentally ill. One study found that readmission rates dropped 50% among clients who had support from their family (Community project, 1994).

Assessment Guidelines

Traditionally, assessment of needs of the CMI has been completed by mental health care providers and usually has been limited to assessment of needs for services available in community mental health centers or though community support programs (CSP). Mental health professionals' assessments of clients' needs are influenced by norms of their profession, whereas, clients' assessments of need are filtered through their sociocultural perspectives, expectations and past experiences (Perese, 1997). In mental

health settings, goals are typically formulated across six "life domains": vocational/educational, social/recreational, independent living/housing, financial, transportation and health and concrete goals are more likely to be achieved than intrapersonal/insight oriented goals (Hodges & Segal, 2002). Lifestyle issues seem more important to the health professionals, whereas, quality of life is the main concern of people with a mental illness (Byrne, Brown, Voorberg, & Schofield, 1999). Self-selected goals are important to the client and are more likely to be reached. When clients determine their own goals, they are usually focused around independent living and socialization. Therefore, it is then important for persons with a mental illness to be encouraged to identify their needs, dictate the terms for their recovery and set realistic and attainable goals (Gibson, 1995).

OT assessment in mental health is mostly comprised of self reported measures, projective tests, interviews, questionnaires, behavior observation scales, tasks and neuropsychological assessments with interviews often used in the screening process. The main functions of an initial interview are to give the therapist an opportunity to judge whether or not the client will benefit from OT intervention, to provide an opportunity to begin to establish rapport and elicit the client's interest and cooperation and finally to produce a database. The process of gathering information highlights the person's strengths, problems and identifies the goals of treatment which are carried out in an environment of respect and empathy. The client must have as much control as possible but, yet, allow the therapist to fulfill his/her aims for the interview. Documents have recommended that clients' performance in self care, work, leisure, psychological skills, social skills and cognitive skills be addressed. An assessment of motor skills should be

included when a client has a physical disability. Any relevant medical information should be recorded and details about the clients relationships are included with family and cultural background history (Orford,1995).

When performing assessments, the OT must pay attention to how clients interpret and perceive their ability to perform daily living activities. It is important to observe their ability to communicate and interact during the assessment. The client's environment must also be taken into account when assessing ability to perform daily activities. The client's ethnicity, cultural and physical environment must be explored; otherwise, irrelevant goals may be set (Mosey, 1986; Peloquin, 1990). OT's must also discover what the person needs to be able to do, what the person is able and unable to do, and the changes that need to be made in the person's patterns of activity and in the environment that will increase the quality of life (Fidler, 1996).

Social Interaction Skills

Adequate social skills are necessary for success in life roles and are essential for individuals to develop supportive social networks, cope with daily stress, improve social functioning and find and hold a job. Assessments can be used, in this aspect, to predict how an individual will function in the community once discharged in from the inpatient setting.

In a study by Penny, Mueser, & North (1995) the Allen's Cognitive Level (ACL) and Social Interaction Scale (SIT) was used to determine if cognitive functioning is related to impairments in social skills. The sample consisted of 59 adults admitted to inpatient units of the Medical College of Pennsylvania at Eastern Pennsylvania Psychiatric Institute. The ACL and SIT were administered independently of each other to

all participants. The results demonstrated strong support for the hypothesis that impaired cognitive ability as measured by the ACL-90 was strongly correlated to impaired social skills as measured on the SIT.

With the current cost of treatment on the rise and the length of treatment shortening, it is imperative to demonstrate the most effective means of improving one's social interaction skills so that an individual can effectively assume necessary social roles (Schindler, 1999; Foto, 1995, 1996). This is achievable through social skill training where the primary goal is to increase or enhance personal skills (Ackerson, 2000).

Schindler (1999) conducted a study at a metropolitan day hospital, with 25 participants who had a severe psychiatric disability, to determine the effectiveness of activity groups and structured discussion groups at improving social interaction skills. The Global Assessment Scale (GAS) was used to determine skill levels and appropriateness of the people for the experimental groups. The Social Functioning Index, a 51-item rating scale of social behavior was adapted to determine the client's level of social skills by using a pre and post test measure.

The structured group was formatted to be purely verbal with the purpose of eliciting social interaction focusing on various aspects of leisure time. The activity group used age appropriate group activities to also explore uses of leisure time such as using the newspaper and phonebook to plan weekend activities. The activity group resembled a project level group. The control groups were provided with table games and participants were allowed to use their time as they chose as long as they returned to their next scheduled group in the day treatment program and their behavior was not disruptive.

The results established that activity groups were more conducive than structured discussion groups or control groups for improving social interaction, which demonstrates that involvement in typical life activities can promote the learning of necessary skills, including social interaction skills, in a natural manner. The presence of a task can provide a non-threatening focus for individuals who find it difficult to interact in social situations and proves to be an effective means of teaching social skills.

Community Living Skills

In order to successfully reintegrate into a community after psychiatric discharge, the individual with a mental illness must obtain the living skills needed to survive and feel as though they have a purpose. These skills may not be acquired during inpatient treatment, but however, can be developed and maintained through community living skills groups.

According to Brown, Shiels, & Hall (2001), in an evaluation of community living skills group, some of the global symptoms presented by people with mental health needs, such as deficits in social and daily living skills, decreased purpose and fewer social interests, can be addressed through Community Living Skills (CLS) training. CLS groups are run by an OT staff within most community mental health teams, usually held on a weekly basis. The group usually includes eight people and is co-facilitated by two staff members, allowing for greater support of members during the practical sessions. A central aspect of a CLS group is its client centeredness which promotes motivation among clients.

A 12-week pilot community living skills group was established with five adults who had mental health needs to promote skills for home management, community living,

personal care and safety along with social and interpersonal functioning. Topics covered in the CLS group included re-socialization, self maintenance and communication (Brown, Shiels, & Hall, 2001).

The Canadian Occupational Performance Measure (COPM) (Law, Baptiste, Carswell, McColl, Poatiajko, Pollock,1994) was used pre and post group in order for clients to identify their perception of the difficulties they were experiencing in independent living and thereby identify goals to address through the 12 week program. A client satisfaction questionnaire was completed by all group members at the end in order to obtain feedback on various aspects of the group. Finally, a home visit was carried out by occupational therapists with group members on an individual basis upon completion of the group to test the client's ability to transfer information from one environment to another.

The topics rated most beneficial were of a practical nature while those enjoyed less were of a digressive nature. The post-group home visits demonstrated an improvement in the majority of group members in effective task management within the home. The results of this study established that a basic form of evaluation can be used effectively to promote good clinical practice and the need for a future CLS groups within treatment.

Poor Physical Health

Poor health care often reflects onto the individual's ability to perform self care. Self care is the behavior performed to meet the individual's needs or self care requisites. This is often an area of concern that the CMI population struggles with, in terms of meeting societal standards. A self care deficit occurs when the individual is not able to

meet his or her self care demands and for persons with health deviation conditions this depends on the person's ability to seek medical assistance for illness, understand the effects of the illness, carry out medically prescribed measures effectively, manage uncomfortable effects of treatment, modify self-image in relation to health, and alter lifestyle to promote or restore health while living with the effects of the illness or pathologic conditions. McFarland & Thomas (1991) determined that an individual's ability to perform self-care is shaped by a variety of basic conditioning factors, such as "age, sexual features, developmental state, health state, sociocultural orientation, socioeconomical elements, health care system elements, family system and patterns of living" (p. 31)

In a study by Getty, Perese, & Knab (1998), the self care capacity of persons with chronic mental illness living in community based residential programs was measured along with the ability of staff members to perform health care functions on their behalf. Four instruments were developed to complete the interviews and review each resident's health record. The Resident's Health Record Review Form is a 33-item form developed to facilitate the review of the physical health portion of the client's record. Data obtained served as an objective base for determining the congruence with the perceptual data subsequently obtained from each resident and the staff participants regarding the respective resident's health and health care. The Health Care Practices Questionnaire is a 94-item instrument with open-ended questions used in interviews to determine the clients' perspective on their health status, understanding of their primary health problem, the ability to understand and perform needed health care actions, ability to maintain healthy lifestyle practices and special concerns in life. The Residence Staff Member

Questionnaire was developed to collect information from select resident staff members regarding their knowledge of the health and health care practices of the participants. Finally, the Lehman's Life Satisfaction Scale was used to evaluate each resident's sense of well being through use of a single item.

Resident participants were interviewed and then the staff person deemed most knowledgeable about that individual was interviewed by a nurse researcher for approximately thirty minutes. The results of the interviews indicated that persons with chronic mental illness, living in the community, lack the ability to manage their health care and determine the appropriate level of medical care required for their health problems. They also lack information about safe sex practices and STD's along with access to preventive interventions. In "surrogate families" of persons with CMI to perform health care functions, it was found that there was a difference between what should take place to maintain the family member's health and what actually occurred. This is especially true regarding nutrition, exercise, rest, smoking, dental care and self-care practices (Getty, Perese, & Knab, 1998).

Health promotion highlights creating environments that are supportive of health in which people are better able to take care of themselves and offer each other support in solving and managing collective health problems. Byrne, Brown, Voorberg, & Schofield (1999) conducted a randomized, controlled trial design study in 22 community group homes in Ontario, Canada to test the effectiveness of two different approaches for health promotion and it's impact on the client's perceived quality of life. A health education group is a more structured leader approach while an empowerment education group is more individually directed. The primary measure of outcome was the Lehman Quality of

Life Scale and the Cantril Self-Anchoring Ladder was used to determine how hopeful individuals were about their life in the past, present and future. This measure allows participants to determine their own baseline of life satisfaction and hope for the future.

Results showed that quality of life scores improved over time, however, there were no statistically significant differences found between the two groups. There were clinically important gains in global quality of life for individuals who endorsed a life low in satisfaction and little hope for the future. Unfortunately, treating this group resulted in increased cost of health services. It is determined that it may be equally effective and less expensive to society to provide individuals with low life satisfaction and with little hope for the future regular group home care. There was a comparable gain in global quality of life between groups for all residents; however, the education approach may be most beneficial for group home residents with the coexisting problems identified (Byrne, Brown, Voorberg, & Schofield, 1999).

Community Residences

Another area that separates the CMI from the rest of the general population and causes difficulty is housing and finance issues. Sociocultural and economic factors contribute to the social drift of vulnerable people with severe mental health problems to cheaper, more anonymous accommodation and in deprived areas psychiatric hospital admissions are three times the national average. Because of insufficient financial resources, clients are often forced to accept housing in undesirable locations which leads to an inability to provide for personal safety to their current housing situation. Clients often had residual disabilities that impaired their judgement and they were frequently robbed or assaulted by people in their neighborhood. Interventions to assist with

rehabilitation and community reintegration are of little benefit until people feel secure and are stabilized in their living situations (Yamada, 2000). An individual's residence with appropriate structure and support may be the greatest factor in successful adaptation to prolonged survival in the community because many persons with CMI who have no home, no family, no network of friends and no role to fill in the community regard community-based residences as their permanent homes and the fellow staff and residents as their family (Getty, et al. 1998). When an individual fails to remain in the community, it seems that maintenance of a living arrangement is one of the first things to deteriorate (Yamada, 2000).

Nelson, Hall, & Walsh-Bowers (1999) conducted a comparative research study in Ontario, Canada to advance understanding of the nature of supportive housing by acknowledging how group homes (GH), supportive apartments (SA), and board and care homes (BCH) differ in terms of housing characteristics, social support, personal empowerment and emotional well being of the people. Also, there is a focus on how the types of housing, demographic variables, housing characteristics and social support related to the personal empowerment and emotional well being of people with psychiatric disabilities.

Group homes are mainly located in an inner city mixed residential and commercial areas while typically accommodating 6-8 people with staff available eight to 24 hours a day. Two to three people live in a SA and they are usually more dispersed throughout the community than GH. BCH are mainly found in inner-city areas. They house up to 30 occupants where meals are provided and there is little emphasis on rehabilitation or community integration. Residents of the BCH were slightly older, had

less education and received higher levels of income (Nelson, Hall, & Walsh-Bowers, 1999).

Information pertaining to empowerment, well being and social support was collected in an initial interview and information regarding living arrangements were collected two months later at an interview. The physical comfort of residents, their perceived level of resident control, measure of democratic style management, personal empowerment, and emotional well being were assessed. Interviews and questionnaires were conducted to determine resident's feelings of empowerment, well being, social support and housing qualities. In order to determine the type of living space, demographic variables, home qualities and dimensions of social support were related to the measures of personal empowerment and emotional well-being (Nelson, Hall, & Walsh-Bowers, 1999).

Results demonstrated that residents of GH and SA report more resident control, and fewer living companions, and are more likely to have their own rooms than those in BCH. There was little difference in the amount of social support available in the different settings. Residents of GH reported higher levels of democratic staff management style and fewer living concerns of than residents of SA. Management style of BCH is typically staff centered while SA is resident centered. Residents of GH and SA report higher levels of personal empowerment but lower levels of emotional well being than those in BCH housing. This is a paradoxical statement, considering one would associate empowerment to be directly related to emotional well being. This may be due to the fact that residents of BCH are older and have found a comfortable place to live, which may be viewed as satisfactory when considering prior living arrangements. The younger

residents of the GH and SA tend to be more oriented to personal growth and change, so therefore, may be dissatisfied with their lives and long for something different (Nelson, Hall, & Walsh-Bowers, 1999).

The type of living space, resident control, and democratic management style are the major predictors of empowerment while social support measures are predictive of emotional well being. Since current trends in community mental health are aimed at enhancing personal empowerment, community integration, and quality of life, it is suggested that housing providers focus on resident independence and support to promote both empowerment and well being.

The authors remind readers that the relationship between the type of living environment, empowerment, and emotional well being is a correlational finding, so no conclusions can be made about the direction of the relationship. The type of living environment, empowerment and emotional well being may all be related in some aspect, however, none of them are causative of the other.

Employment/Work

Work serves an important function in life, such as providing a role in the workforce and an active means of obtaining of obtaining income. Unfortunately, impairments in vocational ability, such as choosing, getting and keeping a job in the community are considered central features of mental disorders (Tsang, et al, 2000). Mental illness is not seen as the only explanation for vocational disability; rather, it is the individual's personal exclusion from work experiences and consequent failure to acquire adaptive skills (Fieldhouse, 2000). Consequently, successful vocational outcomes for persons with CMI remain lower than that of persons with any other disability. At a

national level, it is estimated that 80-90% of people with CMI are unemployed and have a lower chance to be placed and experience more problems in adjusting to work than clients with either learning disabilities or mental retardation (Tsang et al., 2000; Finch & Wheaton, 1999). Premorbid functioning, especially premorbid occupational performance, is a significant and consistent predictor of employment outcomes of the psychiatric population. A client with a good work history is more likely to find employment along with participation in occupational therapy programs may also predict successful vocational outcomes.

In a study performed by Torrey, Becker, & Drake (1995), the community mental health center changed from a day treatment program over a six month period to a supported employment model. Day treatment is a program that provides comprehensive, multidisciplinary services for consumers with severe mental disorders while the supported employment model focuses on integrating vocational and clinical services, rapid job finding, a place-train strategy, competitive jobs in integrated work settings in the community, a team approach and a consumer centered philosophy. Twenty-seven consumers along with 12 local families and seven clinicians who worked in the program during the transition were interviewed two years after the program change to identify the positive and negative aspects of the program change.

All the groups interviewed were consistent with positive evaluations of the program change. Consumers reported increased involvement in other community activities, families and consumers noted increased general supports and the staff identified increased independence among the consumers. However, all three groups also identified that a loss of structured social opportunities was the most negative outcome of

eliminating day treatment. The program is attempting to address social needs by supporting and facilitating consumer-run activities within the region, provide social skill training and regularly organized vocational banquets. However, day treatment emphasizes prevocational activities within a treatment facility rather than directly supporting normal adult roles within the community (Torrey, Becker, & Drake, 1995).

Study results demonstrated that the primary form of psychosocial treatment for clients with severe mental disorders is day treatment, however, psychosocial and vocational rehabilitation programs and assertive community teams in other centers are replacing day treatment centers. Consumers in supported employment programs had significantly better vocational outcomes relative to their previous levels of work and relative to consumers comparable to a day treatment program. Data suggests that emphasizing a culture of employment within the mental health center increases work related structured activities but also promotes independence and community integration (Torrey, Becker & Drake, 1995). This proves the effectiveness of the supported employment model in comparison to day treatment providing new opportunities for restructuring treatment within psychosocial settings.

Interventions aimed at changing attitudes toward work have been found to have little impact on competitive employment outcomes. Another common misunderstanding is that if the skills necessary for finding employment are taught this will lead to higher rates of employment. However, most consumers with CMI need direct assistance finding a job (Corrigan, Reedy, Thadani & Ganet, 1995). Counseling may motivate people to seek employment but if it is not accompanied by direct assistance in helping people find jobs, increasing motivation to work does not directly translate into higher employment

rates. Rehabilitation literature by Vandergoot (1987) and Zadney & James (1977) has also suggested that the amount of counselor time devoted to direct assistance in helping consumers' find and obtain work is associated with higher placement rates into competitive employment, while other activities such as vocational counseling, assessment, and training are not as useful.

Consumer Choice

Consumers have preferences for the types of rehabilitation services they receive; typically they prefer approaches emphasizing rapid job search strategies rather than extended prevocational training. One way to ensure that consumers make informed choices before entering a vocational program is to offer an informational group explaining program options and to ensure that consumers are clear on goals and expectations (Bond, 1998).

A common view among rehabilitation professionals is that people with severe disabilities benefit most from programs offering a range of protected employment options, such as, sheltered workshops, mobile work crews, affirmative industries, agency run businesses, set aside jobs, transitional employment and volunteer jobs (Campbell, 1998; Dincin, 1995; Levin, Chandler & Barry, 1998; Marrone, 1993; Prieve & Depoint, 1987). The theory behind having many options is that consumers can find the level of work best fitting to their capabilities. Following this, people with CMI are placed in less demanding work settings, based on the conclusion that they will eventually gain the skills and confidence to work competitively. However, their research showed when programs offer a variety of jobs, competitive job employment rates are surprisingly low.

The majority of persons with CMI can find a job within several months if they have the desire to work and are assisted in finding a job. Most consumers are motivated to work, if they perceive that the professionals helping them also embrace the belief in the importance and genuinely believe that they can work (Rogers, Walsh, Masotta, & Danley, 1991). However, treatment does not stop as soon as a job is found for the consumer. If it is accepted that the most difficult part is not finding the job but rather keeping the job, then the bulk of assessment efforts should be devoted to assessment after the consumer obtains work. Assessments should be specific to the work environment, with implications for how to intervene, including the development of problem solving strategies. Minor adjustments in job duties or the work environment may increase success on the job. Also, assessing consumers over time has many advantages, including the generation of concrete information for designing behavioral and environmental interventions (Bond, 1998).

Treatment Models

Models provide an organized way of thinking about a certain phenomenon while evaluating the person, environment, health, and occupation. The frame of reference or model will identify what phenomena the treatment should focus on and it will guide the use for instruments. Occupational therapy (OT) is often used to treat psychiatric clients and is a health profession that should sustain theoretical bases in its practice (Mosey, 1996). To achieve such a professional standard, Wu (2000) suggests OT practitioners should scrutinize the consistency between theories and their use in practice rather than simply including theories in practice. Models specific to the psychiatric population that

have proven useful in guiding treatment are the Model of Human Occupation, Cognitive Rehabiliation, Social Rehabilitation, and Psychiatric Rehabilitation.

The Model of Human Occupation (MOHO) (Kielhofner,2002) is an encompassing model concerned with the occupational performance of individuals within their own culture while focusing on motivational aspects of occupation from a psychological and systems perspective (Orford, 1995). There are three primary phenomena addressed by the MOHO. This model is concerned about how persons are motivated toward and choose activities that fill their lives, the constant patterns of doing that we use everyday and finally, that when humans do things, an extraordinary range of capacity for performance is exhibited. The MOHO seeks to understand and explain how occupation is motivated, patterned and performed. Humans are viewed as being made up of three interrelated components: volition, habituation and performance capacity. Volition is the motivation for occupation, habituation is the organization and routine of occupation while performance capacity is the physical and mental abilities that underlie occupation. Volition, habituation and performance capacity contribute in their own manner but have complementary functions to what humans do and how they experience it. By offering explanations of diverse and individualized phenomenon, MOHO offers a broad and integrative view of human occupation (Kielhofner, 2002). People are viewed as unique and potentially unpredictable in their behavior, therefore, behavior is intensely

personal and can only be understood as a reflection of the individual's subjective experience (Bruce & Borg, 2002).

Another approach for occupational therapists in treating persons with CMI is cognitive rehabilitation, which emerged more than a decade ago (Tsang et al., 2000). Cognitive rehabilitation focuses on the client's competencies and weaknesses and then applies intervention strategies, including adaptations and compensatory techniques, often directly derived from the measures used for assessment. A dynamic interactional model is implemented in this approach, which assumes that there are ongoing interactions between the individual, the task and the environment that either facilitate or interfere with the cognitive processing that is needed to participate in everyday life. In order to understand an individual's cognitive processing, an information-processing model has been implemented. This model conceptualizes the cycle in which the individual takes in information, combines it with other information and makes sense of it where decisions can be made and then acted on. This cycle is influenced by what Toglia (1998, pp 8-12) refers to as "learner characteristics" which include metacognition (an individual's ability to judge their own abilities), cognitive processing strategies and personal attributes such as beliefs, motivation, emotions, experiences and styles of coping. When using this approach, the therapist works to uncover clues that will identify the factors that account for the individual's ability to function or for failures to perform successfully in a variety of situations. Then the therapist can work with the client, or other significant individual's

within the client's life, to modify conditions of the task or environment to teach the client cognitive strategies that can be used in multiple situations (Toglia, 1998).

In a different realm of focus is the social rehabilitation approach to client treatment (community living skills or psychoeducational approach) which uses social learning theories and education strategies to improve social functioning (Penny, et al, 1995). The psychoeducational approach in OT aims to strengthen or establish a knowledge base and to change the client's thoughts about one's self esteem from "incapable" to "capable." Educational courses are designed to prepare clients to respond to life's daily challenges which may increase the client's awareness, build functional skills and teach problem solving strategies (Bruce & Borg, 2002).

The community based model, psychiatric rehabilitation (PSR), focuses on individuals that are incapable of performing daily life activities secondary to a severe mental disorder. The central goal of PSR is the prevention of unnecessary rehospitalizations as it aims to improve the long term capabilities of persons with psychiatric disabilities for living, learning, working, socializing and adapting in as normalized fashion as possible. This is achieved through learning procedures and environmental supports (Anthony & Liberman, 1986; Flexer & Solomon, 1993). An emphasis is placed on developing the strategies to manage symptomology and the skills necessary to lead productive lives within the community (Flexer & Solomon, 1993).

The practice of psychiatric rehabilitation, as described by Liberman (1988) is driven by the philosophy that individuals disabled by a psychiatric illness need skills and environmental supports to fulfill the role demands of variety of living, learning and working environments. Interventions are designed to lessen or compensate for the disability which should lead to a decrease in the handicap. It is assumed that by changing the individual's skill level and/or supports in their immediate environment, they will be more capable to perform the specific activities needed to function in their daily roles.

Conclusion

In order to reduce recidivism rates in the chronically mentally ill, multiple theories and models need to be used in order to ensure a holistic approach to treatment. Specified areas of need must be attended to, whether in the community or inpatient setting. Many of these revolve around self care, social interaction skills, adequate housing and finding employment. While it might be viewed as a losing battle trying to end all rehospitalizations, reducing recidivism rates should be possible by implementing needed supports to aid in successful reintegration into the community.

In order to reduce recidivism rates in the chronically mentally ill population, proposed practice strategies will be developed focusing on effective means for treating clients in order to achieve a successful community reintegration. Areas addressed will include types of treatment based on clients' needs, effective models used with the CMI population, guidelines for assessments and general practice. The process used to gain the

information for the therapist guidelines will be described in chapter 3, Activities/Methodology.

Chapter 3: Activities/Methodology:

A review of literature was conducted to determine the type and effectiveness of systematic interventions currently established for the chronically mentally ill population. The literature was formulated from journal articles retrieved through online search engines such as CINAHL, PubMed and OT Search. The information retrieved focused on assessment guidelines and tools, areas of need within the CMI population, treatment methods, and occupational therapy models used with the psychiatric population was conducted.

Based upon this information, a set of practice strategies has been developed revolving around the literature's identification of areas of concern for the chronically mentally ill and the effective treatment methods. The areas of concern identified include: noncompliance with medication and/or planned aftercare, the stigma in society towards the mentally ill, poor social interaction skills, health/self care, and community living skills, difficulty adjusting to community residences upon discharge, difficulty achieving and maintaining employment, and a lack of consumer choice. Behavioral evidence is described for each of the problematic areas along with recommended therapist strategies useful in trying to achieve the goal of successful community reintegration for members of the chronically mentally ill population.

Chapter 4: Product

The product developed from the review of the literature is a set of practice strategies developed to assist therapists in guiding treatment to reduce the recidivism rates in the chronically mentally ill population. The format is structured so that the client's area of need or problem is identified. The literature identified seven problem/challenges (with one area divided into two sections). Behavioral evidence of the problems/challenges is described and followed by recommended therapist strategies addressing client needs to assist in successful community integration within ambulatory behavioral health programs.

Recommended therapist strategies for each problem area are presented and explained. This information would be most useful for occupational therapists practicing in inpatient, outpatient setting or community based services within urban communities These strategies, when implemented, are anticipated to assist in treatment and ultimately reduce the rate of rehospitalizations among the chronically mentally ill.

Occupational Therapy Practice Strategies to Reduce Recidivism Rates in the Chronically Mentally Ill

Part A: Therapist Strategies for Problem/Challenge Areas for the Chronically Mentally Ill

Problem/Challenge #1: Societal Stigma Towards Mentally Ill Acts as a Barrier to Mainstream Society

As Evidenced By:
- Negative community attitudes
- Difficulty accessing mainstream community services (i.e. - jobs, housing, etc.)

Recommended Therapist Strategies:

- Therapists should educate themselves on negative attitudes and ways to combat them (Accordino et al, 2001). Through education, the therapist is able to acquire information on the origin of the stigma, where it is most prominent and then apply the most effective means to dispute these beliefs.

- Education seminars about mental illness to landlords, employers, coworkers, neighbors, etc. The education obtained by the therapist can be used to provide information to community members about mental illness in order to increase their understanding of the disorder and lessen the preconceived notions that are limiting the CMI population's access to community resources.

- Provide information about the National Alliance for the Mentally Ill (NAMI) and National Depressive and Manic Depressive Association (NDMDA) to people important in the client's life. These groups will provide information regarding mental illness and allows individuals close to the psychiatric client to take an active role in their learning about psychiatric disorders.

- Promote contact between CMI population and the general public through community outings. Community outings provide a "safe" means of reintegrating the CMI population back into the community allowing individuals to become re-acquainted with society in a comfortable manner. Positive experiences will promote more community outings, eventually leading towards confident, independent ventures into public.

- Encourage capable clients to write or publicly speak about their own personal experiences of mental illness. Personal accounts of mental illness provide insight into the type of experiences and struggles and individual with a mental illness might have. It provides an intriguing mean of educating the public. Letters to the editor can incorporate this information in local or regional newspapers, magazines, etc.

- Object to a stigma in the media - TV, radio, newspapers, movies and magazines. Complain in writing. Writing provides an effective means of voicing one's opinion against controversial issues. This method allows an individual's statement to be heard publicly and increases awareness of the issue.

Problem/Challenge #2: Multiple Rehospitalizations due to Noncompliance with Planned Aftercare and Lack of Use of Environmental Supports

As Evidenced By:
- Multiple rehospitalizations ("revolving door" syndrome)
- Failure to seek assistance appropriately
- Medication noncompliance
- Treatment noncompliance (follow-up, outpatient)
- Failure to use necessary environmental supports (case management, support groups)

Therapist Strategies:

- Use a standardized discharge planning format involving key elements such as demographics, social and personal resources, anticipated needs of the follow up care, information on medications and follow up appointments (Community project, 1994). With this format, staff and client can be ensured that follow up care is established along with information the client can refer to in order to secure a successful discharge.

- Coordinate discharge follow-up treatment through means of collaborative discharge planning, which is the process involving the client's community support system before hospital release. This involves pre-establishing linkages to existing community-based services, such as partial hospitalization programs or group homes (Community project, 1994). This ensures that supports are available and accessible before the client is discharged from the community.

- A telephone call by the case manager within 48 hours after discharge, during the "critical window", contributes to continuity of care, provides support and offers an opportunity to assess new client medications (Community project, 1994). The "critical window" occurs after the client is discharged from inpatient hospitalization and before the first appointment for outpatient treatment. During this time, many clients experience a personal or mental health crisis and need connections with the health care system but may be unable to access them on their own.

- Advise client about available support networks (i.e. - substance abuse services, crisis response services, income support, peer support/self help, family and community support, etc.). Clients may be unaware of support networks within their community and need information about the service and location before it is accessed.

- Community support program services should be geared to assist former psychiatric patients with survival, treatment compliance, rehabilitation and independent living. Support services may include continued staff/client interaction, case management, medication monitoring and scheduled follow up appointments with the psychiatrist (Gibson, 1995). This allows for continuous tracking of the client's progress and needs so that interventions can be applied before a crisis occurs resulting in another hospitalization.

Challenge #3: Poor Social Interaction Skills (SIS) Cause Difficulty Across Environments.

As Evidenced By:
- Social isolation
- Difficulty interacting with others (i.e.- initiating conversation, maintaining eye contact, etc)
- Workplace problems due to deficits with interpersonal interactions

Therapist Strategies:

- Both social interaction skills and cognition should be assessed using the Allen Cognitive Level (ACL) test as a predictive measure of the individual's social interaction skills in order to grade activities accordingly. Impaired cognitive ability is correlated with impaired social interaction skills. With this knowledge, individual needs and behaviors can be predicted in order to provide interventions and more effective treatment

- Social skills training to combat isolation, loneliness and limited opportunities for social interaction. The primary goal of social skills training is to increase or enhance personal skills so that the individual can effectively assume necessary social roles. Social skill training may involve role playing, modeling of appropriate skills by the therapist, providing instructions to the client, prompting and assigning "homework" to be completed outside the clinic (Liberman, 1988).

- Use of activity groups to promote social skills in clinical setting (rather than structured discussion-based groups) Involvement in typical life activities can promote the learning of necessary skills, including social interaction skills, in a natural manner. The presence of a task can provide a non-threatening focus for individuals who find it difficult to interact in social situations and proves to be an effective means of teaching social skills.

- Structure environment to allow clients to take risks safely. A comfortable environment where a client feels "safe" promotes risk taking in a reassured manner allowing the individual to grow and expand his/her abilities.

- Provide extended programs into nights and weekends to provide members opportunities for social interaction. Some individuals may be employed or have schedule conflicts during regular daily business hours. Extended program hours allow these individuals to access support programs otherwise unavailable but, nonetheless, needed.

Problem/Challenge #4: Difficulty Maintaining Daily Living Skills is a Major Barrier of Successful Reintegration into the Community

As Evidenced By:

- Decreased sense of purpose
- Obvious deficits in activities of daily living (ADL) care
- Difficulty structuring activities during the day
- Disorganized routines making it difficult for the individual to complete the desired occupation

Therapist Strategies:

- Include the client's perception of the difficulties they are experiencing in independent living by using the Canadian Occupational Performance Measure (COPM) to identify and base goals off of this information. The COPM allows the client to identify the importance of certain activities, their quality of performance and the level of satisfaction pertaining to this activity. Client centered goals and interventions can be made based off of the information provided by the COPM.

- Provide groups that are client centered. This allows the participants to learn skills in areas where they feel they are having difficulty. It is also more cost and time efficient to teach skills that are personally relevant to the client.

- Identify client's strengths and weaknesses in occupational performance in order to develop effective interventions. Interventions that are client centered are most effective when using the client's strength to accommodate for his weakness.

- Provide Community Living Skills groups to clients in order to obtain the living skills needed to survive and feel as though they have a purpose. Many individuals with a mental illness have difficulty with areas such as home management, community living, personal care and safety along with social and interpersonal functioning. In order to function as independently and effectively as possible, these skills need to be taught in a structured format to assist in retention and generalization of the skill that would otherwise go unlearned.

- Structure therapeutic environment to support habit training in daily living skills by offering repetitive opportunities in order to engage in routine. The formation of habits reveals an embedding of the information into long term memory of the client, assisting in the generalization of the skill. Habits often lead into routines which promote structured daily routines needed by many CMI clients.

Problem/Challenge #5: **Poor Physical Health Due to an Inability to Determine the Appropriate Level of Medical Care Required for Their Health Problems.**

As Evidenced By:
- Deficits in self-care based on societal standards
- Inability to seek medical assistance for illness
- Inability to manage uncomfortable side effects of treatment
- Inability to modify self-image in relation to health
- Inability to alter or restore health while living with the effects of the illness

Therapist Strategies:

- Assessments, in either a structured format or interview form, can be an effective means to determine the client's perspective on their self care needs along with their actual capacity for self care.

  In order for the therapist to gain insight into the clients' perspective on their health status, understanding of their primary health problem, the ability to understand and perform needed health care actions, ability to maintain healthy lifestyle practices and special concerns in life the Health Care Practice Questionnaire is useful during interviews (Getty, Perese, & Knab, 1998). This provides information to create client centered goals and interventions for treatment.

  The therapist is able to evaluate the client's sense of well being and quality of life through the Lehmann's Lifestyle Satisfaction Scale. This provides information on the client's self perception and their level of insight into their mental illness by measuring satisfaction in nine life domains (Getty, Perese, & Knab, 1998). Treatment can directly reflect the areas of life where the client is currently unsatisfied .

Kohlmann's Evaluation of Living Skills (KELS) to assess self care measure and their ability to seek assistance for medical concerns. The KELS aids in discharge planning by evaluating the client's ability to live independently and safely in the community. Recommendations and supports can be set up based on the information obtained from this evaluation.

- Health promotion groups provided in community residences individually directed to highlight environments that are supportive of health in which people are better able to take care of themselves and offer each other support in solving and managing collective health problems. Providing these groups in community-based residences is as equally effective as groups within the community and decreases costs to society.

- Health education groups, using a structured leader style approach, where healthy lifestyles are promoted, focusing in areas such as nutrition, exercise, rest, smoking, dental care and self care practices. These are equally effective when provided in community-based residences to decrease costs to society.

Problem/Challenge #6: **Housing/Finance Issues Contribute to the Social Drift of Vulnerable People to Cheaper, More Anonymous Accommodations in Deprived Areas Resulting in Multiple Psychiatric Rehospitalizations.**

As Evidenced By:
- Insufficient funds resulting in clients residing in undesirable locations
- Rehospitalizations due to nonpsychiatric reasons such as no income, no place to live and no food

Therapist Strategies:

- Secure appropriate structure and support in housing through an evaluation of housing qualities and client needs. The evaluation provides a more effective means of providing an environment that fits the individual and his/her occupation leading to a greater chance for a successful community reintegration.

- Recommend housing services based on the type of living space, resident control and a democratic management style. These areas are the major predictors of empowerment while social support measures are predictive of emotional well being. Current trends in community mental health are aimed at enhancing personal empowerment, community integration, and quality of life, therefore, housing providers should focus on resident independence and support to promote both empowerment and well being.

- Continuous assessment of the resident's comfort, their perceived level control, measure of democratic style management, personal empowerment, and emotional well being (Nelson, Hall, & Walsh-Bowers, 1999). The continuous assessment provides information to the therapist about the client's functioning and level of satisfaction allowing for interventions to be implemented where needed.

- Install social support measures either within living environment (peer support, discussion groups) or in the community (community support services). Social support services should be directly accessible to the client at anytime to assist in working through difficult times and to prevent hospitalization.

- Provide education about mental illness to the client's landlord while acting like an advocate for the client. This will enhance the landlord's understanding and awareness of the client's disability and strengthen their relationship.

Problem/Challenge #7A: Inability to Find/Maintain Employment in the Community

As Evidenced By:
- Lower chances of placement within employment settings
- Difficulty in adjusting to demands and atmosphere of work environment
- A national level of 80-90% unemployment rate of CMI population (Tsang, Bacon, & Leung, 2000)

Therapist Strategies:

- Research client's work history to determine premorbid functioning. Good premorbid functioning in occupational performance is a significant and consistent predictor of employment outcomes. This information can guide the search for finding a job appropriate to the client's level of functioning.

- Implement the Supported Employment Model focusing on integrated vocational and clinical services, rapid job finding, a place-train strategy, competitive jobs in integrated work settings in the community, a team approach and a consumer centered philosophy. Consumers in supported employment programs have demonstrated significantly better vocational outcomes relative to their previous levels of work and relative to consumers comparable to a day treatment program.

- Emphasize a culture of employment within the mental health center to increase work related structured activities and promote independence and community integration. Requiring the client to manage an increased work load assists in continuous skill development as opposed to work preserving the client's current level of functioning.
  (Torrey, Becker & Drake, 1995).

- Provide direct assistance and counseling to client in finding a job or refer to a case manager. Rehabilitation literature suggests that the amount of counselor time devoted to direct assistance in helping consumers' find and obtain work is associated with higher placement rates into competitive employment, while other activities such as vocational counseling, assessment, and training are not as useful.(Vandergoot, 1987; Zadney & James, 1977).

- Provide assessments specific to the work environment with implications for how to intervene, including the development of problem solving strategies. These assessments will allow for continuous assessment of the client's ability to perform the essential tasks within the work environment. If problem areas develop, they can be discovered and intervened in a structured manner.

- Majority of assessment efforts should be devoted to after after employment is obtained in order to generate concrete information for designing behavioral and environmental interventions (Bond, 1998). It is often accepted that the most difficult part is not finding the job but rather keeping the job and continuous assessment will allow for minor adjustments in job duties or the work environment in order to increase success on the job.

Challenge/Problem #7B: Lack of Consumer Choice Results in Undesirable, Meaningless Jobs That are Difficult to Maintain.

As Evidenced By:
- Placement in less demanding jobs on basis that clients will gain the skills needed for competitive employment
- Inability to acquire employment
- Difficulty in maintaining employment

Therapist Strategies:

- Provide an information group explaining vocational program options to ensure that consumers are clear on goals and expectations of the program. These informational groups ensure that the client is able to make an informed decisions.

- Present clients with an opportunity to choose from programs offering a range of protected employment options, such as, sheltered workshops, mobile work crews, affirmative industries, agency run businesses, set aside jobs, transitional employment and volunteer jobs (Campbell, 1998; Dincin, 1995; Levin, Chandler & Barry, 1998; Marrone, 1993; Prieve & Depoint, 1987). The theory behind having many options is that consumers can find the level of work best fitting to their capabilities and by placement in one setting it is assumed that they will eventually gain the skills and confident to work confidently.

- Demonstrate genuine belief in the client that they re able to work and that it is important to work (Rogers, Walsh, Masotta, & Danley, 1991). Belief in the client motivates the individual to work and achieve his developed goals.

- Teach problem solving skills (implications for how to intervene) within the work setting to increase the client's level of independence and job skill development.

- Assess on a regular basis to generate concrete information for designing behavioral and environmental interventions. Information obtained from these assessments can identify problem areas that are inhibiting the client from functioning at a maximum level and develop interventions accordingly to remediate the problem.

Part B: Therapist Guidelines for Assessments

Problem/Challenge #8: Choosing the Correct Assessment to Effectively Determine Client Needs

Therapist Strategies:

- Evaluate the clients' past and current functioning in order to gain as complete a picture as possible. This includes the clients' status, needs, and goals in the following areas: mental health, physical health, financial status, housing, living skills, leisure, vocational and educational activities, and availability of a support system (Cara & MacRae, 1998).

- Assessment tools that may be considered when evaluating the functional ability of the client include the Kohlmann's Evaluation of Daily Living Skills (KELS), Bay Area Functional Performance Evaluation (BAFPE), the Activity Configuration, Allen's Cognitive Levels (ACL), Comprehensive Occupational Therapy Evaluation Scale (COTE), and the Milwaukee Evaluation of Daily Living Skills (MEDLS).

- Information should be gathered from past records, interview and observation with the client, along with interviews of significant others within the client's environment, such as residential care operators, conservators, family members and former treatment providers.

- Document the client's level of satisfaction within various areas of life in order to gain respect, as a therapist, for the client's individual choice and to facilitate a successful outcome.

- Do not impose your own values and beliefs on clients. Discuss options and resources that may be utilized, and let the clients decide.

Problem/Challenge #9: Selecting and Implementing Theoretical Models to Guide Practice

Therapist Strategies:

- Provide a holistic approach in the delivery of care to persons with a mental illness in order to encompass all aspects of the individual, ranging from daily living skills to environmental concerns. Rehabilitation should begin by targeting psychosocial functioning then extending into community support programs that maintains rehabilitation gains.

- OT practitioners should scrutinize the consistency between theories and their use in practice rather than simply including theories in practice (Wu, 2000). Models specific to the psychiatric population that have proven useful in guiding treatment are the Model of Human Occupation, Cognitive Rehabilitation, Social Rehabilitation, and Psychiatric Rehabilitation.

- Choose theories that support educational courses designed to prepare clients to respond to life's daily challenges which may increase the client's awareness, build functional skills and teach problem solving strategies (Bruce & Borg, 2002).

- Continue to update approaches as theories are updated to keep the knowledge base current with new knowledge and skills gained from working with other disciplines and changes in political, social and cultural perspectives (Neistadt & Crepeau, 1998).

Chapter 5: Summary and Conclusions:

Conclusion:

The practice strategies developed in this project are anticipated to assist practicing occupational therapists in treating clients with chronic mental illness. They are based upon information gained from research studies testing effective treatment methods in reintegrating the CMI population back into the community. These strategies can be used by case managers or any occupational therapist in a treatment setting, such as inpatient, outpatient or community residences. It is anticipated that by implementing the program guidelines into treatment, there will be an increase in the rate of successful community reintegration of the CMI population communities will increase.

Limitations:

Due to the large amount of literature available for treatment methods and information on the chronically mentally ill, resources were not exhausted. Some effective treatment methods/information may not have been obtained and included within this document. This project focuses on a select set of areas of difficulty within this population. Other areas, such as functional mobility, personal hygiene and grooming, and safety responses for example, may need to be addressed with various client populations within the CMI community.

Future research should be directed towards investigating current treatment methods in order to determine their effectiveness within the CMI population. Research

should be conducted in a variety of settings, including inpatient, outpatient, employment settings, community settings, and community residences, to determine the success of treatment interventions across environments.

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